National Association for Behavioral Healthcare

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SUBMITTED VIA: PatientsOverPaperwork@cms.hhs.gov

Ms. Seema Verma
Administrator, Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

17 January 2020

Re: Request for Information; Reducing Administrative Burden To Put Patients Over Paperwork: Scope of Practice Feedback.

Dear Ms. Verma:

On behalf of America's behavioral healthcare providers, the National Association for Behavioral Healthcare (NABH) appreciates the opportunity to provide comments on the Centers for Medicare & Medicaid Services' (CMS) request for information (RFI) on reducing administrative burden to put patients over paperwork "Scope of Practice Feedback" published on December 26, 2019.

Founded in 1933, NABH advocates for behavioral healthcare and represents provider systems that treat children, adolescents, adults, and older adults with mental health and substance use disorders in more than 1,800 inpatient behavioral healthcare hospitals and units, residential treatment facilities, partial hospitalization and intensive outpatient programs, medication assisted treatment centers, specialty behavioral healthcare programs, and recovery support services.

Regulatory Burden on Inpatient Psychiatric Care

Inpatient psychiatric facilities offer critical support to Americans with severe mental health needs and help patients through times of crisis until it is safe for them to continue treatment in the community. Behavioral healthcare providers who provide these services manage countless—and often duplicative—regulations. Easing the regulatory burden for behavioral healthcare providers would improve patient access by allowing these provides to expend their time and financial resources on patient care.

In March 2019, NABH released *The High Cost of Compliance: Assessing the Regulatory Burden in Inpatient Psychiatric Facilities*, a first-of-its-kind report that quantifies the regulatory costs placed on inpatient psychiatric care providers.

That report found that in three regulatory areas—B-tag requirements, ligature risk requirements, and the *Emergency Medical Treatment and Labor Act* (EMTALA)—impose an average annual cost of $1.7 billion on America's inpatient psychiatric facilities. This translates to an annual average of just under $1 million per facility, or more than $18,000 per licensed psychiatric bed.

Meanwhile, the combined cost of all three regulatory areas amounts to approximately 4.8% of an inpatient psychiatric facility's revenue for inpatient psychiatric services. This is a substantial percentage for facilities that have an average net operating margin of negative 5%, particularly when many of these regulatory areas contribute little to ensuring high-quality care.

CMS states in its RFI that the agency's continued goal is to "reduce unnecessary burden, increase efficiencies and improve the beneficiary experience." This is where CMS' goals aligns with those of patients and providers.

Of the three areas identified in NABH's regulatory report, this letter focuses on B-tag requirements and EMTALA. Please read our full report, included with this letter, for more detailed information about ligature risk.

Special Conditions of Participation and B-Tags

Inpatient psychiatric facilities must satisfy the Conditions of Participation (CoP) that apply to all general hospitals, as well as additional CoP that address psychiatric patient evaluations, medical records, and staffing. CMS has issued 60 pages of interpretive guidance regarding the psychiatric hospital CoP, in which the agency defines 60 distinct compliance elements (referred to as B-tags), one or more for each CoP. These rules are intended to serve the important goal of ensuring patient safety and high-quality care; however, some of these requirements are outdated.

In addition, many surveyors apply these criteria indiscriminately in the field, exposing providers to unpredictable citations and requiring costly alterations in their procedures, equipment, and facilities. Taken together, the compliance costs for the B-tags amount to 1.8 percent of inpatient psychiatric care spending, imposing approximately $625 million in costs every year on America's psychiatric facilities.

Of the COP's 60 individual B-tags, we focus here on two sets of B-tags that are particularly problematic: requirements related to documentation in the patient's psychiatric evaluations, and requirements related to minimum qualifications for certain director-level administrative staff.

Upon admission, each patient must receive a psychiatric evaluation (Tag B110). Some surveyors require that this evaluation be conducted by a psychiatrist, even if an advanced practice clinician (APC) — such as an NP or physician assistant — is licensed under state law to conduct such evaluations. Among facilities that have made staffing changes to ensure that psychiatrists are available for these evaluations, the average costs amount to more than $1,000 per day for a 100-bed facility.

Several B-tags require psychiatric facilities to appoint various director-level positions. We focus here on the director of nursing, who must be either: 1) "a registered nurse who has a master's degree in psychiatric or mental health nursing" or an equivalent degree from an accredited nursing school, or 2) a person who is otherwise "qualified by education and experience in the care of the mentally ill." Even though CMS' regulations allow for a nursing director who is "qualified by education and experience," some agency surveyors reveal a clear preference for specific academic credentials. In one recent example, a surveyor questioned the qualifications of a director who had a master's degree in nurse administration, more than three decades of work experience in psychiatric settings, and certifications and continuing education coursework germane to psychiatric care.

This approach contradicts present-day realities in two ways. First, candidates with master's degrees in psychiatric nursing are in short supply. Many individuals who have earned this degree become advanced practice clinicians, rather than hospital administrators. Second, advanced practice nurses may gain years of experience working in psychiatric facilities even if they do not have a degree in psychiatric nursing. Moreover, a registered nurse with psychiatric experience can make an excellent director of nursing, especially if the nurse holds a bachelor's degree in a relevant subject such as hospital management.

Recommendations

CMS should clarify to surveyors that:

- each facility may, if desired, rely on APCs to conduct psychiatric evaluations, subject to applicable state licensure laws that define clinical scope of practice (Tag B110);

- a director-level positions may be designated based on competence in lieu of a specialized master's degree.

CMS should also convene a commission with representation from inpatient psychiatric providers to review the B-tags and determine whether some—or all—of these requirements should be revised or discarded. We appreciate the multiple efforts that CMS has made to change the B-tags around the edges, but it is long past time to take a comprehensive review.

EMTALA

Congress passed EMTALA to ensure that any patient who presents to an emergency department (ED) is screened for emergency medical conditions and, if necessary, stabilized, regardless of the patient's ability to pay. In recent years, however, some regulators have begun interpreting EMTALA in a manner that imposes new requirements on psychiatric facilities.

EMTALA permits each provider to determine which clinicians are designated as "qualified medical persons" (QMPs) who may screen patients for emergency medical conditions. Some regulators, however, use EMTALA to raise the baseline licensure requirements for QMPs in inpatient psychiatric facilities. This approach upends decades of accepted clinical practice. It also fails to account for widespread shortages of clinicians with psychiatric expertise.

Each hospital's QMP criteria may account for individual clinician experience and training in performing various types of emergency screenings, subject to state licensure laws that define the outer limits of each clinician's scope of practice. In many states, for example, nurse practitioners (NPs) are fully independent clinicians who are authorized to diagnose patients, consulting with specialists only as needed (as would a generalist physician).

Registered nurses (RNs) and licensed clinical social workers are often permitted to perform various types of preliminary "assessments," and then consult with a physician or other advanced clinician to establish a disposition and preliminary treatment plan.

Many hospital EDs rely on some combination of NPs, RNs, and social workers to provide emergency medical screenings within their scope of practice. These clinicians may practice alongside ED physicians or psychiatrists, or they may consult with physicians by telephone or telemedicine to confirm a disposition.

Today, however, some federal regulators interpret EMTALA in a manner that imposes baseline licensure requirements on QMPs who perform emergency psychiatric screenings, irrespective of other qualifications or experience:

- For acute care hospitals, regulators have required that the QMP be a psychiatrist rather than an ED physician or APC, such as an NP or physician assistant.

- For freestanding psychiatric hospitals, regulators have required that the QMP be an APC rather than a RN or master's-level social worker.

Congress passed EMTALA to ensure that all patients would receive a screening for emergency medical conditions by a qualified medical professional; Congress did not require that every patient receive a

screening from a medical specialist. In an acute care hospital, ED physicians and APCs are considered competent to diagnose and stabilize a wide range of conditions. Hospitals need not bring in a cardiologist for every heart attack or a gastroenterologist for every case of appendicitis. And as noted above, many states also authorize RNs and social workers to conduct psychosocial assessments and other preliminary screenings.

In sum, CMS' new interpretation of EMTALA's QMP requirement fails to respect the clear federal rule permitting each facility to designate QMPs within the limits set by state licensure laws; fails to accord parity to psychiatric and non-psychiatric emergency medical screenings; and fails to recognize the reality of psychiatric staffing shortages

A separate EMTALA issue relates to patients who are involuntarily committed. Some psychiatric facilities do not accept involuntarily committed patients, and have long maintained a policy of transferring such patients to more appropriate facilities, often in accordance with standing transfer agreements established under state-run programs. Some regulators, however, are now requiring all inpatient psychiatric facilities with an ED to admit involuntarily committed patients, notwithstanding the risks for other patients and for hospital staff when patients are admitted involuntarily absent proper precautions, including additional staffing and training. EMTALA should not be used to address the shortage of facilities that treat involuntarily committed patients. Federal regulators should respect state procedures for involuntary commitment, including state arrangements for facility designation and patient transfer.

Recommendations

- CMS and the U.S. Department of Health & Human Services Office of Inspector General (OIG) should ensure that surveyors respect EMTALA's clear direction that each provider's medical staff may decide for itself which clinicians are competent to screen for emergency medical conditions, subject to applicable state licensure laws that define clinical scope of practice.

- General hospitals, psychiatric facilities, and their medical staffs should be permitted to designate QMPs based on qualifications and competence, up to the limit of each clinician's scope of practice as defined under state law. If a facility deems an ED physician or RN qualified to serve as a QMP, surveyors should respect that determination, absent evidence of patient harm or a violation of law.

- EMTALA should not be used to address the shortage of facilities that treat involuntary committed patients. Federal regulators should respect state procedures for involuntary commitment, including state arrangements for facility designation and patient transfer. Regulators should not use the threat of EMTALA sanctions to force all psychiatric facilities with an ED to accept involuntary admissions, especially at the potential expense of the voluntarily admitted patients' safety and treatment.

Conclusion

Adopting fewer burdensome requirements would benefit the healthcare system by reducing unnecessary costs and providing greater stability and predictability for providers as they navigate the regulatory environment. In addition, patients would benefit as clinicians would be able to shift more of their attention, and facilities would be able to shift more of their resources, away from compliance for compliance's sake and toward initiatives that meaningfully contribute to safe, high-quality care.

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We look forward to continuing our work with you to help identify other opportunities for CMS to maintain flexibility and efficiency in the Medicare program through regulatory, sub-regulatory, policy, practice, and procedural changes. If you have questions, please contact me directly at 202-393-6700, ext. 100, or at shawn@nabh.org.

Thank you for your consideration.

Sincerely,

Shawn Coughlin
President and CEO